

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION, BERGEN COUNTY

FILED

APR - 1 2009

Jonathan N. Harris
J.S.C.

IN RE: DIGITEK® LITIGATION

Case No. 283

Civil Action

Applicable to All Cases

BER-L-917-09MT

CASE MANAGEMENT ORDER NO. 1

THIS ORDER is being entered following a Case Management Conference with counsel on March 27, 2009. This Order is effective March 27, 2009.

I. PLAINTIFF FACT SHEET

1 Plaintiffs shall provide fully responsive answers to the agreed upon *Plaintiff Fact Sheet* (hereinafter "*PFS*") attached as Exhibit "B" in the currently filed cases as set forth on Exhibit "A," no later than **May 1, 2009**.

2 Plaintiffs in all future filed actions shall serve fully responsive answers to the *PFS* no later than 30 days after service of the first Defendant's *Answer* to the Complaint or other responsive pleading.

III. DEFENDANTS' PRODUCTION OF DOCUMENTS

3 The Defendants shall, for the purposes of this litigation but with the appropriate substitution of the New Jersey Rules of Court for the Federal Rules of Civil Procedure, comply with paragraph IV(b) of *Pre-trial Order No. 16* entered in *In Re: Digitek Products Liability Action*, MDL 1968 ("*MDL PTO No. 16*") and produce documents to the Plaintiffs on or before the dates set forth in paragraph IV(b)(all dates shall be calculated from March 5, 2009, the date that *MDL PTO No. 16* was entered, not from March 27, 2009, the effective date of this *Case Management Order*).

IV. MEET AND CONFER

4. Attorneys for the Parties shall meet and confer no later than **April 13, 2009**, to attempt to resolve by consensus any outstanding issues including but not limited to the following:

- a. a *Master Complaint*, *Short-form Complaint* and a *Master Answer*;
- b. a *Preservation Order* (for tangible and intangible things);
- c. the identification of any particular witness whose status and availability might be in question due to ill health, death or a change in employment status (i.e. from retirement, termination or a reduction in workforce, or otherwise; and,

5. The Parties shall submit the framework for a proposed Consent Order on these issues.

V. UTILIZING THIRD-PARTY ELECTRONIC SERVICE

6. The Parties shall be permitted to employ a third-party electronic service, such as Lexis-Nexis, for the serving of papers on and amongst each other.

7. Notwithstanding the employment of any such a third-party electronic service provider all filings in this litigation with the Court must be done in accordance with the New Jersey Rules of Court and not by means of electronic filing.

VI. INTERROGATORIES AND DOCUMENT PRODUCTION

A. Newly Served Interrogatories

8. Whether a party has served interrogatories previously or not, any party may propound and serve interrogatories on the other party, no later than **June 15, 2009**.

9. Fully responsive answers to any newly propounded interrogatories shall be served no later than **July 31, 2009**.

B. Previously Served Interrogatories and Request for Production of Documents

10. Defendants shall serve on opposing counsel by **April 6, 2009** fully responsive answers/responses to *Plaintiffs' Interrogatories and Requests for Production Directed to Defendants Set 1* propounded upon Defendants on February 2, 2009.

11. The term “fully responsive” shall mean that each interrogatory will be answered in detail, and to the extent that an answer refers to a document, bates-page number or a range of bates page number shall be supplied which identify the document being referred to.

12. All documents supplied shall be bates-numbered.

13. To the extent information is withheld by any party, either pursuant to confidentiality, a privilege or as work-product or other reason, that party shall provide a privilege log in accordance with R. 4:10-2(d), which will identify the bates-number or bates-range of the document withheld and further provide sufficient identification of the document so the Court could rule on any requests by any party seeking production of the document.

VII. PROTECTIVE ORDER

14. To the extent the parties cannot agree on a *Protective Order*, the parties shall each respectively file and serve their proposed version of a *Protective Order* together with a Brief in support of their version no later than **April 3, 2009**.

15. The parties shall file and serve their Reply briefs no later than **April 8, 2009**.

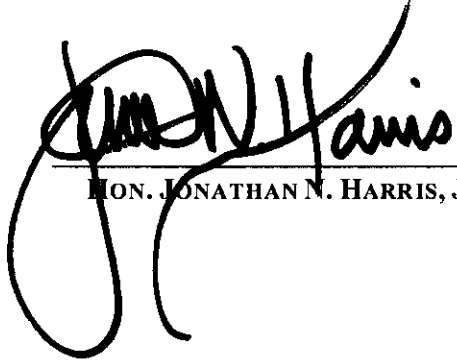
16. The expedited disposition of the parties' disputes over the *Protective Order*, without the necessity of the filing of a formal motion, is being accomplished by the Court for good cause shown and is not intended to be the rule of the case for the resolution of future disputes. The resolution of future disputes between the parties shall be accomplished by formal motion practice absent a

showing of good cause.

VIII. NEXT CASE MANAGEMENT CONFERENCE

17. The next *Case Management Conference* will take place in Courtroom 301 on August 7,
2009 at 1:30 p.m.

Dated: April, 2009



HON. JONATHAN N. HARRIS, J.S.C

| | Docket # L- | Plaintiff's Name |
|----|------------------------|----------------------------------------------|
| 1 | L-918-09 | Brown, Winell |
| 2 | L-1121-09 | Keoughan, Joan |
| 3 | L-1174-09 | Bradley, Barbara |
| 4 | L-1288-09 | Hickman, Mary M. |
| 5 | L-1289-09 | Milroad, Carole |
| 6 | L-1319-09 | Merola, Anna Mae |
| 7 | L-1323-09 | Estepp, Regina |
| 8 | L-1321-09 | Wilson, Dorothy |
| 9 | L-1322-09 | Bellamy, Dona E. & Bellamy, Louis W. H/W |
| 10 | L-1325-09 | Hoover, Bertina E. & Hoover, Ronald H/W |
| 11 | L-1327-09 | Mariam, Phillip & Mariam, Richard |
| 12 | L-1328-09 | Bradway, Marlene L. & Bradway, Marlin H/W |
| 13 | L-1329-09 | Mcanly, Jeanette |
| 14 | L-1339-09 | Bratcher, Jerry & Bratcher, Sharon H/W |
| 15 | L-1342-09 | Hergert, Joyce A. |
| 16 | L-1344-09 | Fricker, Ronald & Fricker, Catherine H/W |
| 17 | L-1345-09 | Williams, Roy |
| 18 | L-1346-09 | Paler, Heather M. |
| 19 | L-1347-09 | Stevens, Priscilla J. |
| 20 | L-1348-09 | Steadman, Cassie L. |
| 21 | L-1349-09 | Agathos, Valerie |
| 22 | L-1350-09 | Russo, Dean |
| 23 | L-1351-09 | Ramsey, Carl & Ramsey, Athalee |
| 24 | L-1352-09 | Koproski, Jeffrey |
| 25 | L-1353-09 | Duran, Gerald |
| 26 | L-1354-09 | Nufrio, Marie |
| 27 | L-1355-09 | Herring Charlie, Herring Suzanne |
| 28 | L-1356-09 | Tipton, Bonnie S. |
| 29 | L-1357-09 | Hadden, Linda C. |
| 30 | L-1358-09 | Benjamin, Joseph |
| 31 | L-1359-09 | Christel, Karin |
| 32 | L-1360-09 | Heller, Belinda |
| 33 | L-1361-09 | Moreno, Fernando |
| 34 | L-1362-09 | Collins, Mary |
| 35 | L-1363-09 | Vincent, Marty M. |
| 36 | L-1364-09 | Kyle, Lennett |
| 37 | L-1365-09 | Massey, Loren |
| 38 | L-1366-09 | Hilliard, Pat |
| 39 | L-2018-09 | Cheely, Jean |
| 40 | L-227-09 | Frey, David P. , and Frey, Paul L. |
| 41 | L-2718-09 | Lita, Barbara |
| 42 | L-2724-09 | Boddie, Marian F. |
| 43 | L-2786-09 | Heffner, Eugene & Heffner, Shirley |

IN RE: DIGITEK® LITIGATION

Applicable to all Cases

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION
BERGEN COUNTY

Case No. 283

Civil Action

BER-L-917-09MT

PLAINTIFF:

(Name)

DIGITEK® PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers and as a response to requests for production under the New Jersey Rules of Court. The questions and requests for production contained in the Fact Sheet are non-objectionable and shall be answered without objection. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge.

In filling out this form, please use the following definition: "healthcare provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In addition, to the extent that the form does not provide enough space to complete your responses or answers, please attach additional sheets as necessary.

1. CASE INFORMATION

1. Please state the following for the civil action that you filed:

a. Case caption: _____

b. Case Number: _____

d. Your attorney:

Name: _____

Address: _____

2. Name of person completing this form: _____

3. Please list any other names you have used or by which you have been known and dates you used those names:

4. Your current address: _____

5. If you are completing this Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

a. Describe the capacity in which you are representing the individual or estate:

b. If you were appointed as a representative by a court, state the:

Court Which Appointed You: _____

Date of Appointment: _____

c. What is your relationship to the individual you represent: _____

- d. If you represent a decedent's estate, state:

Decedent's Date of Death: _____

Address of Place Where Decedent Died: _____

- e. If you are claiming the wrongful death of a family member, identify any and all family members, beneficiaries, heirs or next of kin of that person, including their relationship to Decedent:

THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO PURCHASED AND USED DIGITEK®. WHETHER YOU ARE COMPLETING THIS FACT SHEET FOR YOURSELF OR FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE DIGITEK® PURCHASER AND USER.

II. CLAIM INFORMATION

1. Name of Digitek® Purchaser/User: _____

2. Have you used any other names in the last five (5) years? Yes ____ No ____

If Yes, please list any such names that you have used: _____

3. Do you claim that you suffered bodily injuries as a result of taking Digitek®?

Yes ____ No ____ If Yes, please answer the following:

a. What bodily injuries do you claim resulted from your use of Digitek®?

b. When is the first time you saw a health care provider for your alleged injury? _____

c. Are you currently experiencing symptoms related to your alleged injury?

Yes ____ No ____ If Yes, please describe the symptoms: _____

d. Who diagnosed your injury? _____

e. Did you see a doctor, clinic or healthcare provider for the bodily injury or illnesses listed above?

Yes ___ No ___ If Yes, who:

f. Date of diagnosis: _____

g. Were you hospitalized?

Yes ___ No ___ If Yes, please answer the following:

1) Date of hospital admission: _____

2) Date of discharge: _____

3) Hospital name and address: _____

i. Have you had any discussions with any doctor or other healthcare provider about whether Digitek® caused you to suffer any illness or injury?

Yes ___ No ___ If Yes, who: _____

4. Are you claiming mental and/or emotional damages as a result of taking Digitek®?

Yes ___ No ___

If Yes, what mental and/or emotional damages do you claim resulted from your use of Digitek®?

If Yes, for each provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric or emotional problems, in the last ten years state the following:

| NAME | ADDRESS | CONDITION TREATED | DATES TREATED | MEDICATIONS PRESCRIBED |
|------|---------|-------------------|---------------|------------------------|
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5. Are you making a claim for lost wages or lost earning capacity?

Yes___ No ___ If Yes, state the annual gross income you derived from your employment for each of the last five (5) years:

6. Have you incurred any out-of-pocket expenses as a result of using Digitek®?

Yes___ No ___ If Yes, please identify and itemize all out-of-pocket expenses you have incurred:

7. What other damages, if any, do you claim you suffered as a result of the purchase or ingestion of Digitek®?

III. DIGITEK® PRESCRIPTION INFORMATION

1. Have you ever used Digitek®? Yes___ No ___

2. If you answered Yes to No. 1, identify the following for each period of time during which you took Digitek®:

| DOSAGE (.125 MG OR .250 MG) | HOW OFTEN PER DAY OR WEEK? | DATE STARTED | DATE STOPPED | NAME OF PRESCRIBER |
|-----------------------------------|----------------------------------|--------------|--------------|-----------------------|
| | | | | |
| | | | | |
| | | | | |

3. Name(s) and address(es) of pharmacies where prescriptions were filled: _____

4. Identify the condition for which you were prescribed Digitek®: _____

5. Did you receive any free samples of Digitek®?

Yes ___ No ___ If Yes, please state the following:

a. Who provided the samples? _____

b. When were samples provided? _____

c. What was the dosage of the samples? _____

d. How many samples were provided? _____

6. Do you have in your possession or does your attorney have the packaging from the Digitek® you allegedly purchased, or purchased and used, and/or any Digitek® tablets?

Yes ___ No ___

a. If yes, who currently has custody of the Digitek® packaging and/or tablets?

b. If you or your attorney is in possession of tablets, how many do you have? _____

c. Have you or anyone on your behalf tested the Digitek® tablets in your possession?

Yes ___ No ___

7a. Do you know the lot number(s) for any of the Digitek® you received?

Yes ___ No ___

If Yes, what is/are the lot number(s): _____

7b. Do you know the expiration date for any of the Digitek® you received?

Yes ____ No ____

If Yes, when is/was/were the expiration date(s): _____

8. Have you had any communication, oral or written, with any of the defendants or their representatives?

Yes ____ No ____

If Yes, set forth the date of the communication, the method of communication, the name of the person with whom you communicated, and the substance of the communication between you and any defendants or their representatives:

9. Have you ever used any other digoxin or digitalis product?

Yes ____ No ____

If Yes, please state:

| DOSAGE (.125 MG OR .250 MG) | HOW OFTEN PER DAY OR WEEK? | DATE STARTED | DATE STOPPED | NAME OF PRESCRIBER |
|-----------------------------------|----------------------------------|--------------|--------------|-----------------------|
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10. Are you aware that Digitek® was recalled on April 25, 2008?

Yes ____ No ____ If Yes, please state the following:

a. When you became aware of the recall: _____

b. How you became aware of the recall: _____

11. Did you discuss the Digitek recall with any healthcare provider or pharmacist?

Yes ____ No ____ If Yes, please state the following:

a. When that discussion occurred: _____

b. With whom: _____

12. Did you return any Digitek® to Stericycle or any pharmacy?

Yes ____ No ____ If Yes, please state the following:

a. When did you return the product? _____

b. Do you have any paperwork regarding the return? Yes ____ No ____

c. To whom did you return the product? _____

13. Have you ever visited a website, chat-room, message board or other electronic forum containing information or discussion about Digitek®?

Yes ___ No ___ If Yes, please provide the name of the website: _____

IV. MEDICAL BACKGROUND

1. Current Height: _____
2. Current Weight: _____
3. Approximate weight at the time of your injury: _____
- 4.A. To the best of your knowledge, have you, or any blood-relative family member (child, parent, brother, sister, or grandparent), ever experienced or been diagnosed with any of the following conditions? Please select **Yes**, **No** or **I Do Not Know** for each condition. For each condition for which you answer **Yes**, please identify who suffered the condition, you or a relative, and please provide the relative's name and relationship to you. If you suffered the condition, please provide the additional information requested in the table following 4(B):

| CONDITION EXPERIENCED OR DIAGNOSED | YES | NO | I DO NOT KNOW | WHO SUFFERED CONDITION |
|------------------------------------------------------------------------------------------------------|-----|----|------------------|---------------------------|
| Abnormal heart rhythm, atrial fibrillation, atrial flutter, ventricular fibrillation, or heart block | | | | |
| Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis) | | | | |
| Blocked or narrow arteries/plaque buildup/coronary artery disease | | | | |
| Cardiomyopathy/enlarged heart | | | | |
| Chest pain/angina | | | | |
| Congenital heart abnormality | | | | |
| Congestive heart failure | | | | |
| Heart attack/MI/myocardial infarction | | | | |
| High blood pressure/hypertension | | | | |
| High cholesterol or triglycerides | | | | |
| Kidney disease or condition | | | | |
| Stroke/transient ischemic attack/TIA/aneurysm | | | | |

- 4.B. To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions? Please select **Yes**, **No** or **I Do Not Know** for each condition. If you suffered the condition, please provide the additional information requested in the table following this chart:

| CONDITION EXPERIENCED OR DIAGNOSED | YES | NO | I DO NOT KNOW |
|---------------------------------------------------------------------------------------------------------|-----|----|---------------|
| Alcoholism or other substance abuse | | | |
| Alzheimer's, senility, confusion | | | |
| Arthritis (osteoarthritis or rheumatoid arthritis) | | | |
| Autoimmune diseases (e.g., rheumatoid arthritis, lupus, Sjogren's, etc.) | | | |
| Bleeding or clotting disorders | | | |
| Cancer | | | |
| Chronic obstructive pulmonary disease/COPD/chronic lung disease/asthma | | | |
| Deep vein thrombosis/DVT | | | |
| Depression, anxiety, schizophrenia, bipolar disorder | | | |
| Dermatologic diseases or conditions | | | |
| Diabetes mellitus | | | |
| Electrolyte imbalance | | | |
| Enlarged prostate, bladder dysfunction | | | |
| Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD, increased or decreased motility) | | | |
| Hardening of the arteries/stenosis/aneurysms | | | |
| Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation) | | | |
| Hormonal replacement therapy | | | |
| Hypothyroidism/Thyroid condition | | | |
| Immune system disease or dysfunction | | | |
| Liver disorder or disease (cirrhosis, hepatitis, etc.) | | | |
| Multiple sclerosis, myasthenia gravis | | | |
| Osteoporosis, bone fractures, calcium deficiency | | | |
| Peripheral vascular disease or peripheral arterial disease | | | |
| Pulmonary embolism/blood clot to the lungs | | | |
| Pulmonary hypertension | | | |
| Raynaud's syndrome/phenomenon | | | |
| Rheumatic Fever/Scarlet Fever | | | |
| Tobacco use or addiction | | | |
| Vasculitis | | | |

For each condition for which you answered **Yes** in the previous two charts, please provide the information requested below, to the extent that you can recall:

| CONDITION YOU EXPERIENCED | DATE OF ONSET | MEDICATION / TREATMENT | I DO NOT RECALL | TREATING PHYSICIAN AND/OR HOSPITAL | I DO NOT RECALL |
|---------------------------------|------------------|------------------------------|--------------------|------------------------------------------|--------------------|
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5. Please indicate whether you have ever been the subject of any **cardiovascular surgeries** including, but not limited to, open heart/bypass surgery, CABG, pacemaker or defibrillator implantation, stent placement, vascular surgery, angioplasty, IVC filter placement, carotid (neck) surgery, or valve replacement.

Yes ___ No ___ I don't recall ___ If Yes, please specify the following:

| SURGERY | REASON FOR SURGERY | DATE | TREATING PHYSICIAN | HOSPITAL |
|---------|-----------------------|------|-----------------------|----------|
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6. Please indicate whether you have ever been the subject of any of the following **cardiovascular diagnostic tests** or interventions and provide the requested information about each: including, but not limited to, stress test C-reactive protein (CRP); chest X-ray; angiogram/catheterization; CT scan; MRI; EKG; echocardiogram; TEE (trans-esophageal echo); endoscopy; lung bronchoscopy; carotid duplex/ultrasound; MRI/MRA of the head/neck; angiogram of the head/neck; CT scan of the head; bubble/microbubble study; and Holter monitor.

Yes ___ No ___ I don't recall ___ If Yes, please specify the following:

| DIAGNOSTIC TEST/ INTERVENTION | REASON FOR TEST/ INTERVENTION | DATE | TREATING PHYSICIAN/ HOSPITAL | RESULT OF DIAGNOSTIC TEST/ INTERVENTION |
|----------------------------------|-------------------------------------|------|------------------------------------|-----------------------------------------------|
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7. Do you now or have you ever smoked tobacco products? Yes ___ No ___ If Yes, please specify the following:

- a. How long have/did you smoke? _____
- b. How much do/did you smoke? _____

8. Did you drink alcohol (beer, wine, etc.) in the three years before your alleged injury?

Yes ___ No ___ If Yes, please specify the following:

- a. How often did you drink? _____
- b. How much did you drink? _____

9. Have you ever used any illicit drugs of any kind within the five (5) years before, or at any time after, your alleged injury?

Yes ___ No ___ If Yes, identify the substance(s) and your first and last use: _____

V. ADDITIONAL MEDICATIONS (INCLUDING OTHER DIGOXIN PRODUCTS, SUCH AS LANOXIN®)

1. For any medications, herbal products or supplements other than Digitek® that you took on a regular basis in the ten (10) years prior to, and at the time of, the incidents described in your Complaint, please provide the information requested below:

| NAME OF MEDICATION USED | DOSAGE | PRESCRIBING PHYSICIAN | DATES OF USE | PURPOSE OF PRESCRIPTION |
|-------------------------|--------|-----------------------|--------------|-------------------------|
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2. Have you ever experienced any side-effects while you were taking any of the medications identified in this section in the past ten (10) years?

Yes ___ No ___ If Yes, please specify the following:

- a. The name of the medication: _____
- b. The side effect(s): _____
- c. The date the side effect was experienced: _____

VI. PERSONAL INFORMATION

1. Current Address and Date when you began living at this address: _____

2. Social Security Number: _____

3. Date and Place of Birth: _____

4. Marital Status: _____

If married, spouse's name, occupation and date of marriage: _____

If divorced, dates of the marriage, case name/jurisdiction for the divorce: _____

Has your spouse filed a loss of consortium in this action? Yes ___ No ___

5. If you have children, please list each child's name and date of birth:

6. For any school attended after High School, please provide the following information:

a. School Name: _____

b. Address: _____

c. Dates attended: _____

d. Diploma/Degree: _____

7. Employment information for the last ten (10) years. Please include employer's name, address, dates of employment, job title, job description and duties:

8. Have you ever served in the military, including the military reserve or National Guard?

Yes ___ No ___

If **Yes**, were you ever rejected or discharged from military service for any reason relating to your physical condition? Yes ___ No ___

If **Yes**, state the condition for which you were rejected or discharged:

9. Has any insurance or other company, or Medicare or Medicaid, provided medical coverage to you or paid medical bills on your behalf in the last ten (10) years?

Yes ___ No ___

If **Yes**, please specify the following:

- a. The name of the company/agency: _____
- b. Address: _____
- c. Dates of Service: _____

10. Have you applied for workers' compensation (WC) and/or social security disability (SSI or SSD) benefits in the last ten (10) years?

Yes ___ No ___

If **Yes**, please specify the following:

- a. Type of claim: _____
- b. Year application filed: _____

- c. Agency where application was filed: _____
- d. Nature of disability: _____
- e. Time period of disability: _____

11. Have you filed a lawsuit or made a claim in the last ten (10) years, other than in the present suit, relating to any bodily injury?

Yes ___ No ___ If Yes, please specify the following:

- a. Court in which suit/claim filed or made: _____
- b. Case/Claim Number: _____
- c. Nature of Claim/Injury: _____

12. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty?

Yes ___ No ___ If Yes, please set forth where, when and the felony and/or crime: _____

VII. HEALTHCARE PROVIDERS AND PHARMACIES

1. Identify each doctor or other healthcare provider who you have seen for medical care and treatment in the past ten (10) years:

| NAME AND SPECIALTY | ADDRESS | REASON FOR VISIT | APPROX DATES/YEARS OF VISITS |
|--------------------|---------|------------------|------------------------------|
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2. Identify each hospital, clinic, or healthcare facility where you were hospitalized (in-patient, out-patient, or emergency room visit) in the past ten (10) years:

| NAME | ADDRESS | ADMISSION DATE(S) | REASON FOR ADMISSION |
|------|---------|-------------------|----------------------|
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3. Identify each pharmacy that has dispensed medication to you in the past ten (10) years:

| NAME OF PHARMACY | ADDRESS | APPROX DATES/YEARS YOU USED PHARMACY |
|------------------|---------|--------------------------------------|
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VIII. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. If you are filling this out on behalf of an individual who is deceased, please state the following from the Death Certificate of the individual:

(NOTE: In lieu of the following, please attach a copy of the death certificate.)

Date of death: _____

Place of death (city, state and county): _____

Facility or location where death occurred: _____

Name of physician who signed death certificate: _____

Cause of death: _____

If you are filling this out on behalf of an individual who is deceased and on whom an autopsy was performed, please fill in the information below pertaining to the autopsy and the autopsy report:

(NOTE: In lieu of the following, please attach a copy of the autopsy report.)

Date: _____

Performed by: _____

Facility where autopsy was performed: _____

Place where autopsy was performed (city, state, county): _____

Describe any and all tissue preserved: _____

IX. FACT WITNESSES

1. Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their name address and his/her/their relationship to you:

Name: _____

Address: _____

Relationship to you: _____

Name: _____

Address: _____

Relationship to you: _____

Name: _____

Address: _____

Relationship to you: _____

Name: _____

Address: _____

Relationship to you: _____

Name: _____

Address: _____

Relationship to you: _____

IX. DOCUMENT DEMANDS

1. Authorizations: please sign authorizations that are attached hereto as Exhibit A, for each of the healthcare providers that you have identified above in your Answers to §II, Question Nos. 1-3, and § IV, Question No. 2.
2. Documents in your possession, including writings on paper or in electronic form: If you have any of the following materials in your custody or possession, please attach a copy to this Fact Sheet.
 - a. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Digitek®.
 - b. Copies of the entire packaging, including the box and label, for Digitek® and any Digitek® tablets (plaintiffs or their counsel must maintain the originals of the items requested in this subpart).
 - c. All documents relating to your purchase of Digitek®, including, but not limited to, receipts, prescriptions or records of purchase.
 - d. Representative samples of all photographs, drawing, journals, slides, videos, DVDs or any other media relating to your alleged injury.
 - e. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).
 - f. Decedent's death certificate and autopsy report (if applicable).
 - g. Medical records, bills, correspondence, reports and all other documents from any health care provider who saw, evaluated or treated Plaintiff/Decedent in the last ten (10) years.
 - h. All emergency responder, paramedic or EMT reports regarding Plaintiff/Decedent.
 - i. Documents concerning any communication between Plaintiff/Decedent and the FDA or any Defendant regarding the events giving rise to the lawsuit or relating to Digitek, or documents concerning any communication between Plaintiff/Decedent's attorneys and any Defendant regarding the events giving rise to the lawsuit or relating to Digitek. (This paragraph does not include any obligation to produce correspondence from Plaintiff's counsel to Defense counsel, or correspondence between Plaintiff's counsel and the FDA.)
 - j. Non-privileged documents, including any diaries, calendars or notes that record Plaintiff/Decedent's health, use of Digitek or alleged injuries, on and after one year prior to the alleged onset of Digitek related injuries.

X. VERIFICATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge. I have supplied all the documents requested in Part IX of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and supplied the authorizations attached to this declaration.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in any material respects incomplete or incorrect.

Date: _____

Signature

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF INFORMATION PURSUANT TO 45 C.F.R. 164.508

Patient Name: _____

Identification: Date of Birth Date of Death Soc. Sec.
Parents Name/Previous Name(s) _____

Provider: _____

(Who is releasing
the information)

Requestor: Name RecordTrak
(to whom the information Address 651 Allendale Road
will be provided) King of Prussia, PA 19406

Information Requested: I authorize the disclosure of all protected medical information, from the time period 1998 to present, in written or electronic form for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and completed protected health information, including, but not limited to, the following:

- All medical records, including, but not limited to: inpatient, outpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes; and records received from other physicians or health care providers;
- Reports of all laboratory, histology, cytology, pathology, radiology, toxicology, CT Scan, MRI, echocardiogram & cardiac catheterization;
- Copies of all radiology films; myelograms; CT Scans; photographs; bone scans;
- While this authorization applies to reports of pathology, cytology, histology, autopsy, immuno-chemistry specimens, production of originals or recuts or other specimens, shall be by separate agreement and request.
- All pharmacy prescription records, including, but not limited to: NDC numbers and drug information handouts/monographs
- All billing records, including, but not limited to: all statements, itemized bills, and insurance records.
- All documents related to amendment of any record requested.

Purpose of Release: For the purpose of review and evaluation in connection with a legal claim.

This authorization expires when the following event occurs: 2 years from the signature date below. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to RecordTrak. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. This information, once it is released, may be re-disclosed by the recipient, and if re-disclosed, the information would no longer be protected by the federal privacy rule. Any facsimile, copy or photocopy of the authorization authorizes you to release the records requested herein.

Signature of Patient if 18 years of age or older _____ Date _____

Signature of Parent or Legal Representative _____ Date _____

Relationship to Patient, if not signed by Patient _____

SPECIFIC authorization for release of information protected by state or federal law in addition to the authorization and other provisions contained above, hereby incorporated by reference, I authorize: (i) the release of data and information (limited to the time-period of 1998 to the present) only) to RecordTrak; and (ii) RecordTrak's re-disclosure of the data and information to Tucker Ellis & West, LLP and/or Shook Hardy & Bacon, LLP; any and all data, notes, records, reports, and/or any other documents and information relating to:

X 1. Substance Abuse (Alcohol/Drug) X 2. Mental Health (includes psychological testing) 3. HIV-related information (AIDS related testing)

This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$500, in the case of a first offense, and not more than \$5000 in the case of each subsequent offense. Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175); Comprehensive Alcohol Abuse Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

Signature of Patient if 18 years of age or older _____ Date _____

Signature of Parent or Legal Representative _____ Date _____

Relationship to Patient, if not signed by Patient _____

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF EMPLOYMENT INFORMATION

Employee Name:

Identification:

Date of Birth:

Soc. Sec:

Parents Name/Previous Name(s)

Provider:

*(Who is releasing
the information)*

Requestor:

*(to whom the information
will be provided)*

Name RecordTrak

Address 651 Allendale Road

King of Prussia, PA 19406

I authorize the disclosure of all protected information in any form (including oral, written and electronic) for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and completed protected employment information spanning the time period of **1998 to present**, including, but not limited to, the following:

- All applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files, disability records; records submitted in connection with any claims by all physicians, psychologists, psychiatrists, hospital and testing facilities, radiologists, and any and all other health care providers; records of any payments made; records of any litigation resulting from denials of coverage;
- All insurance records, claim forms, renewal records, questionnaires and records of payments made, all insurance policies, and employee benefit records certificates and benefit schedules regarding the insured's coverage, including supplemental coverages; health and physical examination records reviewed for underwriting purposes; questionnaires and records submitted in connection with the applications or renewals;
- All hospital, physician, clinic, infirmary, nurse, psychiatric, psychological and dental records; x-rays, test results, physical examination records and other medical records, medication records;
- All documents related to amendment of any record requested;
- All records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports;
- All pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; and
- Any other records concerning employment of the Employee named above.

Purpose of Release:

For the purpose of review and evaluation in connection with a legal claim brought by _____.

This authorization expires when the following event occurs: the resolution of litigation. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to RecordTrak. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. This information, once it is released, may be re-disclosed by the recipient, and if re-disclosed, the information would no longer be protected by the federal privacy rule. Any facsimile, copy or photocopy of the authorization authorizes you to release the records requested herein.

Signature of Employee if 18 years of age or older _____ Date _____

Signature of Legal Representative _____ Date _____

Relationship to Employee, if not signed by Employee _____

**AUTHORIZATION FOR RELEASE OF
DISABILITY CLAIMS RECORDS**

To:

Name

Address

City, State and Zip Code

This will authorize you to furnish copies of any and all records of disability claims of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, for the time period of 1998 to the present, concerning:

Name:

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of defendants in the Digitek® litigation, who have agreed to pay reasonable charges made by you to supply copies of such records:

Name RecordTrak

Address 651 Allendale Road

King of Prussia, PA 19406

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as though the original had been presented to you.

Date: _____

Claimant/Guardian/Personal Representative Signature